United Behavioral Health

Compliance: System for Prompt Response to Compliance Issues			**Policy Identifier/Number:** AD-01G
Annual Review Completed Date: February 2018			
Policy Category: Government - Pierce Regional Support Network	**Applicable Lines of Business:** Medicaid	**Entity/Plan:** Optum Pierce Behavioral Health Organization	**State:** Pierce County, Washington
Approved by: Bea Dixon, Executive Director			**Signature:** B. Dixon

Policy Statement and Purpose

It is the policy of the Optum Pierce Behavioral Health Organization (BHO) Compliance Program to review and investigate credible reports of noncompliance and fraud, waste or abuse. Additionally, it is the policy of the Optum Pierce BHO Compliance Program to report and remediate substantiated findings.

Policy Audience and Applicability

This policy is applicable to the Optum Pierce BHO and benefits administered through the Washington State Department of Social and Health Services (DSHS) current Prepaid Inpatient Health Plan (PIHP) and Behavioral Health State Contract (BHSC).

Policy Definitions

Abuse refers to community behavioral health agency or entity actions that are inconsistent with sound fiscal, business, or medical practices and results in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Compliance Officer refers to an employee hired by the Optum Pierce BHO Executive Director to fulfill this role in compliance with Federal Program Integrity requirements and contractual requirements with the Washington State Department of Social and Health Services.

Fraud refers to an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to them or some other person and includes any act that constitutes fraud under applicable federal or State law.

Waste refers to unintentional overutilization, underutilization, or misuse of resources.

Optum is responsible for adhering to all applicable state and/or federal laws governing activities within the scope of this policy, including the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, as well as the applicable requirements, standards and regulations as set forth by the Employee Retirement Income Security Act (ERISA), the Center for Medicare and Medicaid Services (CMS), the Department of Labor (DoL), and any applicable accrediting organizations.

Policy Provisions

1. All reports of noncompliance and fraud, waste, or abuse and associated investigations are kept confidential unless required by law, regulation or company policy.
2. Compliance investigations are initiated as soon as reasonably possible following receipt of the reported concern and conducted as expeditiously as required.
3. After a determination has been made that a referral or tip should be investigated, and that a full investigation is warranted, the Compliance Officer performs the following investigative steps.

    3.1. The Compliance Officer must analyze the information to determine priority by considering:

        3.1.1. The impact of the case upon the consumer. For example, if a consumer is receiving multiple treatments that are potentially harmful, the case should be given a high priority. Treatments negatively affecting a consumer's health and/or insurability are factors in making this judgment.

        3.1.2. The financial impact of the case. If the case consists of a large dollar amount, the case has a larger impact and should be given a high priority.

    3.2. Developing an action plan that plots the course and describes the scope of the investigation and the approaches to be employed. The investigative work plan includes tasks to be performed during the investigation and is flexible to allow for modification as the situation demands.

    3.3. The investigative work plan includes a timeline for the accomplishment of specific tasks.

    3.4. Generally, any investigation will feature the following elements:

        3.4.1. Identifying potential sources of information on the matter in question;

        3.4.2. Gathering relevant information from those sources through medical records, interviews or data collection;

        3.4.3. Recording the results of the investigation in writing; and

        3.4.4. Evaluating investigative findings and potential resolution strategies in cooperation with the team, the Counsel or a Medical Director;

        3.4.5. Initiating a resolution strategy.

    3.5. In conducting investigations, the Compliance Officer collects information and evidence from a wide variety of sources.

        3.5.1. Internal sources consist, in part, of past abuse & fraud cases or intelligence files;

        3.5.2. claim/encounter data history extracts via data analysis tools;

        3.5.3. canceled checks;

        3.5.4. original claim forms;

        3.5.5. 1099 reporting;

        3.5.6. internal experts:

        3.5.7. medical director,

        3.5.8. care management,

        3.5.9. Optum Pierce BHO functional units

3.5.10. External sources of information/evidence collection include, but are not limited to present or former employees of a suspect community behavioral health agency; present or former consumers; other community behavioral health agencies in the community, or business associates of the subject; a subject's present or former spouse; the subject himself or herself; prior complaints and allegations made by state or federal agencies or departments of professional regulation, and any media reports on same; public court records; Department of Motor Vehicle records; online sources, i.e., the internet; consumer advocate groups, i.e., public citizens and the Better Business Bureau; Medicare sanction list; Office and hospital medical records; law enforcement; if a foreign claim: passport and airline tickets/ itinerary; IRS tax identification verification line; information shared by other insurers; vendors that provide such services as surveillance (photos, audio & video), interviews or public record searches; asset checks; and the referring party.

3.6. In the final stage of the case, the Compliance Officer, in consultation with the investigative team**,** determines recommended actions based on substantiated findings.

3.7. The Compliance Officer convenes the Compliance Committee and presents a summary of findings. The Optum Pierce BHO Governing Board is likewise kept apprised of compliance-related activities.

4. If after the initial investigation and consultation with the Optum Piece BHO Executive Director, Compliance Officer and/or legal counsel, it is determined there are genuine compliance concerns, Optum Pierce BHO will forward reports of potential fraud and abuse to DSHS/DBHR and all other appropriate regulatory authorities.

5. Optum Pierce BHO Executive Director, Compliance Officer or designee notifies the Washington State Medicaid Fraud Control Unit (MFCU) as soon as suspected fraud, waste or abuse is discovered. The Executive Director, Compliance Officer or designee additionally notifies the DSHS Incident Manager and the Optum Corporate Compliance staff within one working day of any compliance incident that was referred to the MFCU by the BHO or its Subcontractor.

6. If fraud or abuse, suspicious or unethical conduct is suspected in contractors who are reimbursed to serve individuals in the Optum Pierce BHO, the Executive Director, Compliance Officer, or designee will report the potential fraud and abuse information to the Medicaid Fraud Control Unit whenever it is suspected.

6.1. When notifying the Medicaid Fraud Control, Optum Pierce BHO includes:

6.1.1. Source of the complaint or the data reviewed that raised the concern

6.1.2. Name of the community behavioral health agency(s) who are suspected of involvement

6.1.3. Approximate number of dollars in question

6.1.4. Legal and administrative disposition of the case

6.2. Optum Pierce BHO notifies the DSHS Incident Manager and the Optum Corporate Compliance office within one working day of any incident that was referred to the Medicaid Fraud Control Unit by the BHO or its Subcontractor.

6.3. If DSHS determines it is in the State's best interest for the Washington Attorney General to pursue the potential fraud and abuse, Optum Pierce BHO will cooperate fully with any with any investigation conducted by the State or federal authorities, including the Medicaid Fraud Control Unit (MFCU), the DEA, the FBI and other investigatory agencies.

6.4. If, after discussion with DSHS and Corporate Optum Behavioral Health Compliance Unit, Optum Pierce BHO is directed to proceed, Optum will send Provider Relations, Clinical and/or IT staff to the community behavioral health agency site to review encounter data received against the community behavioral health agency's clinical record for a sample of consumers. The inquiry or investigation may include interviews of relevant personnel and review of relevant documentation regarding the matter as well as pertinent laws, regulations and policies and procedures.

6.5. As necessary, once the preliminary investigation has been completed, results will be reported to DSHS or other DSHS designee and with the Corporate Optum Behavioral Health Compliance Unit.

7. If fraud or abuse, suspicious or unethical conduct is suspected in community behavioral health agencies that have been reimbursed to serve individuals in behavioral health services in the Pierce BHO, the Executive Director, Compliance Officer, or designee, reports the potential fraud and abuse information to DSHS whenever it is suspected.

7.1. When notifying DSHS, Optum Pierce BHO includes:

7.1.1. Source of the complaint or the data reviewed that raised the concern

7.1.2. Name of the contracted agency and names of behavioral health care community behavioral health agency(s) who are suspected of involvement

7.1.3. Names of the contracted agencies and names of employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in *SSA Section 1128* within 10 business days of awareness of the conviction.

7.1.4. Approximate number of dollars in question including any payments made by the contractor or subcontractor that directly or indirectly benefited excluded employees, individuals and/or entities.

7.1.5. Legal and administrative disposition of the case, including any actions taken by Optum Pierce BHO to terminate relationships with the contractor or subcontractors' employees, individuals or entities with an ownership or control interest.

7.2. Optum Pierce BHO notifies the DSHS Incident Manager and the Corporate Optum Behavioral Health Compliance Unit within one working day of any incident that was referred to the Medicaid Fraud Control Unit by the BHO or its Subcontractor.

7.3. If DSHS determines it is in the state's best interest for the Washington Attorney General to pursue the potential fraud and abuse, Optum Pierce BHO cooperates fully with any investigation conducted by state or federal authorities, including the Medicaid Fraud Control Unit (MFCU), the DEA, the FBI and other investigatory agencies.

7.4. If, after discussion with DSHS, Optum Pierce BHO is directed to proceed, Optum shall conduct the Investigative Steps detailed under B: Internal Investigative Steps, below.

7.5. Once the preliminary investigation has been completed, results will be reported to DSHS and the Optum Corporate Compliance staff. The report will include any evidence gathered.

8. Following are the resolution strategies commonly pursued in resolving cases:

8.1. Closing the case may be the best option when the evidence does not support findings of inappropriate benefit payments or the legal or medical merits of the case are ill defined.

8.2. If investigation results indicate that the claim contained unintentional billing errors, the community behavioral health agency will be contacted, advised of the errors and provided with tips on appropriate billing techniques.

8.3. When the results of an investigation do not indicate that all of the elements of fraud have been established, the Compliance Officer may flag a community behavioral health agency or consumer in the system to monitor future activity to determine if a pattern of fraud or abuse is evident.

8.4. Optum may include discipline and/or network dismissal.

8.5. Pursuing mediation or arbitration.

8.6. Optum will file a civil suit against a community behavioral health agency or consumer to recover defrauded funds. Optum attorneys will consider the merits of each case and proceed in a manner which they determine is legally sound.

9. Due to confidentiality and privacy concerns, reporters of noncompliance may not be told of how an issue is resolved. However, Optum Pierce BHO will be able to advise if allegations were substantiated.

Related Policies, Procedures & Materials

- Optum Pierce Behavioral Health Organization policy:
    - *AD-01A Compliance: General Compliance Policy*
    - *AD-01B Compliance: Governance and Oversight*
    - *AD-01C Compliance: Communication and Reporting*
    - *AD-01D Compliance: Training and Education*
    - *AD-01E Compliance: Routine Auditing and Monitoring*
    - *AD-01F Compliance: Enforcement of Disciplinary Guidelines*

Attachments

N/A

Approval History

- Policy created and effective: February 2018